The Leadership Institute
of the
Southeastern Conference on Alcohol
and Other Drug Programs Inc.

August 18-23, 2002

The University of Georgia Center for Continuing Education
Athens, Georgia

Southeastern Conference on Alcohol and Other Drug Programs Inc.

Board

Leadership Institute Staff

James A. Neal, *Director*
Southeastern Conference on Alcohol and Other Drug Programs Inc.
Columbia, South Carolina

Jerri Speyerer, *Co-Director*
Mississippi Department of Mental Health
Jackson, Mississippi

Carolyn R. Dunlap, *Proceedings Editor*
South Carolina Department of Alcohol and Other Drug Abuse Services
Columbia, South Carolina

A Special Thanks

The Southeastern Conference on Alcohol and Other Drug Programs Inc. is pleased to have as a cosponsor of the Leadership Institute this year the Southeast Addiction Technology Transfer Center (SATTC), a project of the Center for Substance Abuse Treatment, located at the Morehouse School of Medicine. Special thanks to Kimberly N. Sutton, Ph.D., director of the Cork Institute on Black Alcohol and Other Drug Abuse at the Morehouse School of Medicine, for her support of and participation in the Leadership Institute.

Final Report of the Leadership Institute of the 42nd Annual Southeastern School of Alcohol and Other Drug Studies

Preface

On Sunday, August 18, 2002, 20 professionals drawn from the fields of substance abuse and juvenile justice gathered at The University of Georgia Center for Continuing Education in Athens, Georgia, to participate in the Leadership Institute held as part of the 42nd Annual Southeastern School of Alcohol and Other Drug Studies. These individuals, who are viewed as emerging leaders in their fields, were invited to participate in the weeklong Leadership Institute by the executive directors of the state alcohol and drug abuse authorities in the eight Southeastern states of Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. Appendix I provides a listing of the participants of the Leadership Institute.

Modeled after the American Assembly established by Dwight D. Eisenhower at Columbia University in 1950, the Leadership Institute involved participants in four days of highly interactive "dialogue sessions" through which they addressed a topic of major significance to the field of ATOD programming. The topic, titled "Substance Abuse Among Juvenile Offenders: Policy Issues for Prevention and Treatment," was identified and selected by the Southeastern Conference on Alcohol and Other Drug Programs Inc.

The Leadership Institute was designed to accomplish several objectives: (1) to promote networking among program leaders from throughout the Southeastern region; (2) to assist the leaders in reaching conceptual clarity on key issues related to the topic of dialogue; (3) to assist the leaders in reaching consensus on these key issues; and (4) to develop a consensus report on the topic to be disseminated to the participants of the Leadership Institute and to the other students in attendance at the Southeastern School, as well as to the directors of the state alcohol and drug abuse authorities in the eight Southeastern states and to other interested groups and individuals as appropriate.

The participants prepared for the dialogue sessions by reading a background paper on the topic of substance abuse among juvenile offenders prepared for the Leadership Institute by James A. Neal, M.C.J., CSPP, and Kimberly N. Sutton, Ph.D. The paper did not claim to be all-inclusive in regard to its topic area, but instead, it attempted only to raise key concerns and thereby encourage meaningful dialogue among the participants.

On Monday, August 19, 2002, participants were provided with an orientation to the Leadership Institute by James A. Neal, director, and Jerri Speyerer, co-director, followed by a keynote panel presentation by Kimberly N. Sutton, Ph.D., director of the Cork Institute on Black Alcohol and Other Drug Abuse at the Morehouse School of Medicine. Following these

presentations, participants of the Leadership Institute began their dialogue on the topic of substance abuse among juvenile offenders.

It is important to point out that the participants took part in "dialogue" groups throughout the week as opposed to the more common practice of "discussion" groups. According to Peter Senge, author of *The Fifth Discipline: The Art and Practice of the Learning Organization*, the discipline of group learning starts with "dialogue" – the capacity of members of a group to suspend assumptions and emerge into a genuine "thinking together." To the Greeks, "dia-logos" meant a free-flowing of meaning through a group, allowing the group to discover insights not attainable individually. "Dialogue" differs from the more common "discussion" which shares its roots with "percussion" and "concussion" and is literally defined as a heaving of ideas back and forth in a winner-takes-all competition.

Although the practice of dialogue has been preserved in some cultures, such as the American Indian culture, it has been almost completely lost to modern society. For this reason, participants of the Leadership Institute were encouraged to follow the principles and practices of dialogue during these sessions and were encouraged to establish the following norms during the dialogue sessions:

- suspend assumption and judgment;
- accept one another's experiences as true and real for them;
- work to understand one another's experiences and perceptions, rather than debating them;
- allow moments of silence;
- balance speaking from the "head" with speaking from the "heart"; and
- listen carefully to what others have to say.

During the week, participants were assigned to one of two dialogue groups. Each time the dialogue groups met, the participants were asked to volunteer to serve as or to elect all of the following:

- a facilitator – to assist the group with identifying the task and keeping the dialogue on track;
- a reporter – to record key points of dialogue on issues, to review the key points at the close of each session, and to submit copies of the key points to the proceeding drafters;
- a process observer – to assist the group with staying on task;
- a timekeeper – to remind members of the time remaining in the session; and
- an ambassador (optional) – to carry messages to the other group.

Each group reporter used a dialogue session reporting form that provided a framework for capturing the consensus of the group on issues related to the topic. In addition, following the keynote panel presentation, participants were asked to modify the questions for dialogue contained within the framework to reflect new input or issues not covered. Reports from both groups were synthesized into one proceeding that was then reviewed by all participants at two designated times during the week.

Following are the background paper prepared for the Leadership Institute and the consensus report of the participants. Although not all participants expressed agreement with all of the recommendations provided in the consensus document, the report represents consensus as achieved through the group dialogue process. While the report reflects general consensus, no one was asked to sign it, and not every participant subscribed to every conclusion or recommendation therein.

Substance Abuse Among Juvenile Offenders: Policy Issues for Prevention and Treatment

Background Paper

by
James A. Neal, M.C.J., CSPP
and
Kimberly N. Sutton, Ph.D., NCC, LPC

Introduction

The purpose of this paper is first to provide the participants in the 2002 Leadership Institute with an introduction to the conceptual framework of the Institute and what to expect during the week. However, the majority of the paper will attempt to provide a snapshot of many of the issues related to substance abuse among juvenile offenders that influence the scope and depth of policies and programs regarding this problem within the Southeastern states. The authors have attempted not to reach conclusions about the merits of specific policies or programs; the Leadership Institute participants will do that work as they draw on their wealth of knowledge and experience. In addition, this paper does not claim to contain all of the policy and program issues related to substance abuse among juvenile offenders. Neither does the paper reflect positions endorsed by the Southeastern Conference on Alcohol and Other Drug Programs Inc.

Leadership Institute participants will receive on arrival a copy of *Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide*, a 1999 publication of the U.S. Center for Substance Abuse Treatment, for a more detailed examination of research and policy issues related to treatment than this paper will attempt. Participants are also encouraged to acquire a copy of a special issue of *Youth & Society*, titled "Bringing Restorative Justice to Adolescent Substance Abuse," Vol. 33, No. 2, December 2001.

The reader is encouraged to approach this document as a framework for dialogue among the participants of the Leadership Institute that can lead to consensus on relevant policy and program issues. Dialogue issues will be listed at the end of the paper. Leadership Institute participants are encouraged to identify additional policy and program issues that are relevant to the problem of substance abuse among juvenile offenders that are not contained within this paper and to raise those issues during the week. In addition, participants are encouraged to bring copies of information related to this topic, such as journal articles, editorials, fact sheets or books, with them to the Leadership Institute so this information can be shared with participants throughout the week.

Why a Leadership Institute?

Continuous improvement programs are not a new concept to service providers as organizations strive to improve their operations in an environment that is increasingly competitive. Unfortunately, many of these efforts are simply a repeat of old practices. There

are numerous reasons this can occur. For the sake of brevity, this paper will address only a couple of these reasons.

One reason for repetitive practices is because organizations and individuals fail to grasp a basic truth – that continuous improvement requires a commitment to learning. (Garvin, 1993) Without an ongoing process of improving actions through better knowledge and understanding, changes in policies and programs frequently are cosmetic and short-lived. Organizations that are moving toward a new way of learning have been described as "learning organizations" or "knowledge-creating companies." (Kofman and Senge, 1993) A simple definition of a learning organization is "an organization skilled at creating, acquiring, and transferring knowledge, and at modifying its behavior to reflect new knowledge and insights." (Garvin, 1993) Organizations moving in this direction have incorporated three attributes within their processes for doing business. These are:

1. Aspiration – Individuals, teams and eventually the larger organization become increasingly able to focus on the things they truly care about and to make changes that promote those priorities;
2. Dialogue – Members of the organization, both individually and collectively, are increasingly able to reflect on and talk about long-held assumptions and behaviors. They develop the art of dialogue, not the "talking at you" form of communication that often passes for conversation in workplaces and in society at large; and
3. Conceptualization – The organization recognizes that ideas, issues and problems look very different when viewed from different perspectives.

The Southeastern Conference on Alcohol and Other Drug Programs Inc. created the Leadership Institute to model these attributes as much as possible within the short period of time participants spend together. Participants are invited to the Leadership Institute by the eight state directors of the single state authority on substance abuse that make up the Conference to utilize this process to examine in depth a major policy issue selected each year by the Conference and to reach consensus on policies that can provide guidance to public and private providers of alcohol, nicotine and other drug services in the region. In previous years, Leadership Institute sessions have explored in depth the following topics: "Managed Care: Implications for Alcohol, Tobacco and Other Drug Prevention and Treatment," "Harm Reduction: Implications for Alcohol, Tobacco and Other Drug Prevention and Treatment," "Holistic Treatment," "Systemic Barriers to Prevention and Recovery," "Prevention: The Search for Direction," "Tobacco Road…The Twisted Path: Policy Issues for the Future," "Women Who Use and Abuse Substances: Policy Issues for Prevention and Treatment," and "Domestic Violence and Substance Abuse."

During the Leadership Institute, participants are asked to place emphasis on the process of dialogue to develop consensus on policy and program issues. Dialogue comes from two Greek words, "dia" and "logos." The original meaning suggests "meaningful flowing through." Isaacs (1993) defines dialogue as a "sustained collective inquiry into the processes, assumptions and certainties that compose everyday experience." Dialogue asks participants to be non-judgmental listeners. Consensus goes a step beyond dialogue. The root of the word means "to feel together." In consensus building, participants seek rational ways of limiting options and focusing on the ones that are most acceptable to the most people. By combining dialogue and consensus, the participants of the Leadership Institute can create an environment that promotes focused dialogue on true values and beliefs about the policy and program issues

surrounding a particular topic (i.e., substance abuse among juvenile offenders) facing public and private service providers in the Southeast.

Another reason why organizations frequently falter in their quality improvement efforts is because of our tendency as a nation, as organizations and as professionals to view problems through a microscope, rather than through binoculars. We see the "trees" – individual components of problems – but miss the "forest" – the entire context in which the problems occur. This collective tendency toward "tunnel vision" often results in a mixture of beliefs about health and social problems. Our nation's record of approaches to reduce problems resulting from the use of alcohol, nicotine or other drugs by persons of all age groups and both genders through prevention or treatment reflects numerous examples of a lack of consensus and vision. For example, many people believe that personal weakness or poor parenting causes individuals to abuse alcohol, nicotine or other drugs: they uphold the ideal of rugged individualism that is ingrained in our history and culture that portrays problems with substances as individual weaknesses or morality issues that can be overcome by strong-willed individuals. Others believe that some other factor – such as the lack of education, the lack of feelings of self-efficacy, the failure of parents to provide adequate social skills, or living in communities that lack opportunities for meaningful employment – is the root of the problem.

Not surprisingly, our approach to preventing and treating substance use and abuse problems among high-risk youth reflects these diverse perspectives as well. Entire organizations are funded to devote their efforts to one part of the problem and, in doing so, these organizations sometimes fail to acknowledge the entire system in which young people use alcohol, nicotine and other drugs and in which problems occur. This "single focus" approach to a public health or safety problem is further complicated by a crisis mentality that often results when limited resources are available to address an unlimited problem. When this occurs, a single problem – such as the use of crack cocaine by minority youth – often becomes the political and media "priority." Because resources tend to flow toward these "priorities," organizations and professionals become conditioned to follow the money if they hope to stay in business and remain employed. A crisis mentality diminishes the individual's and the organization's ability to see the big picture – to research, plan and evaluate programs that address the real causes of serious health problems. This "single focus" is further confounded when organizations become so caught up in the mission dictated by their funding source that they operate as if they are unaware of the interrelationship among major health and social problems. They focus on a single problem and operate in such a way as to discourage communication, coordination and collaboration. For example, a state or community program that is funded to reduce the use of nicotine among young people cannot ignore the risk factors that are common to all adolescent problem behaviors or the differences in social pressures on males and females; neither can it ignore the research on nicotine's impact on specific neural systems that foster compulsive drug-seeking behavior if they are to understand and address the behavioral nature of dependence. Such organizational "tunnel vision" results from (and promotes) turf issues, categorical funding and a crisis mentality. In addition, it frequently results in policy and program failure. Although some programs may achieve exceptional results, these "chimneys of excellence" seldom have a lasting impact on the larger community.

The Leadership Institute is designed to allow participants to "step aside" from organizational stereotypical thinking and pressures and examine through the art of dialogue what science and

practice suggest should be the guiding principles of policies and programs that provide substance abuse prevention and treatment for juvenile offenders.

Why a Leadership Institute on substance abuse among juvenile offenders?

The Southeastern Conference on Alcohol and Other Drug Programs Inc. chooses topics for the Leadership Institute that pose important issues to state and community providers of alcohol, nicotine and other drug prevention and treatment services in policy design and program implementation.

There exists little debate within the United States that the non-medical use of psychoactive drugs, including alcohol and nicotine, is one of the major causes of health problems as reflected in the adverse physiological effects of use (overdoses, alcohol cirrhosis, drug-related birth defects, etc.); behavior while under the influence (impaired driving, domestic violence, crime, etc); and consequences inherent in administration (carcinogens in tobacco smoke, human immunodeficiency virus and other serious infections transmitted through shared injection equipment), to name a few examples.

Certainly the use, abuse and addiction to alcohol, nicotine and other drugs by youth present very complex issues to families, schools and communities. Use on the part of adolescents has been studied since 1975 through the National Institute on Drug Abuse funding of Monitoring the Future, an annual study conducted by the University of Michigan's Institute for Social Research. Findings from the 2001 study show that 54 percent of youth have tried an illicit drug by the time they finish high school and that more than a third had done so as early as the 8th grade. Three out of 10 have used some illicit drug other than marijuana by the end of the 12th grade. Use of "licit" drugs, nicotine and alcohol, remains high. Nearly two-thirds of youth have tried cigarettes by the 12th grade and 30 percent of 12th graders report being current users. Four out of every five students have consumed alcohol by the end of the 12th grade.

Substance use is associated with the three highest causes of mortality among young people: injury, suicide and homicide. It is also associated with sexually transmitted diseases, unwanted teenage pregnancies and mental health problems. In addition, substance use at an early age is more likely to lead to dependence and its associated problems than when substance use begins at a later age. (*Manual of Adolescent Substance Abuse Treatment*, 2001)

According to the Robert Wood Johnson Foundation in announcing its program, titled "Reclaiming Futures: Building Community Solutions to Substance Abuse and Delinquency," 60 percent of the 1.7 million youth processed through the juvenile justice system each year have some level of substance abuse-related problem. If this projection is even close to being on target, it means that substance-using youthful offenders are dominating the juvenile justice system. However, it is estimated that only 1 in 16 youth who need substance abuse treatment actually receives it. (*Youth & Society*, 2001)

Defining a health problem that is also a social problem and developing policies and programs to ameliorate that problem is a matter involving popular beliefs and ideology. Obviously, the use of substances by persons of all ages, and adolescents in particular, is a problem that is not easily solved. Examining adolescent use of substances as it relates to juvenile delinquency presents an additional dimension. An in-depth exploration of the beliefs, policies and

approaches to preventing and treating substance abuse among juvenile offenders is far beyond the scope of this paper, which will focus on the following two general questions:

1. What are the program and policy issues that need to be addressed to improve the outcomes of current juvenile offenders who have some level of substance use problems?
2. What are the evidence-based programs and strategies needed to prevent substance use and/or juvenile delinquency among youth?

Before looking at these two areas, the Leadership Institute participants will be asked to dialogue about some of the beliefs that have influenced the scope of our current policies and programs. Among these are:

Do adolescents and adults want the same things in life? Robert Bly, the author of *The Sibling Society* (1996), talks about his view of how our culture has become one where adults remain children and children have no desire to become adults. Bly argues that adolescents and adults look to their respective peer groups to validate social norms and behavior. One result of this "vertical gaze" is a spiritual flatness. The talk show replaces the family. Instead of art, we have the Internet. In the place of community, we have the mall. In this sibling culture, Bly suggests that the young and disenfranchised frequently turn to psychoactive substances to alter the impact of their reality. Hence, substance abuse prevention and treatment programs that fail to recognize the rapid change in how adults and adolescents find values in our society may not be as successful as hoped. Since most prevention and treatment programs are designed and administered by adults, how best to promote their "fit" with the target population becomes a major question.

Should any use of alcohol, nicotine or other drugs by young people be considered as "abuse"? Federal policymakers recommend using the term "abuse" for any illicit substance use, which includes any use of alcohol and nicotine among persons who are younger than the required purchase age for these substances. The argument is that this makes sense in terms of a clear and consistent message of "zero tolerance" for substance use among adolescents. (*Manual of Adolescent Substance Abuse Treatment*, 2001) Critics of this approach say that it is unrealistic to expect adolescents to be substance free in the face of promotion, access and availability of alcohol, nicotine and other drugs and that this approach continues to place the focus on the drug and not the level of abuse. They argue for a change in policies and laws that will place the focus on reducing harm to the individual user and society. Advocates of harm reduction approaches believe policies should be based on the following:

1. People of all ages, including adolescents, will use psychoactive substances. Non-medical use is inevitable in any society that has access to such substances. Policies cannot be based on a utopian belief that non-medical use will be eliminated. A drug-free community would be as improbable as a sex-free community. (Duncan, et.al. 1994)
2. Use of psychoactive substances will inevitably produce important social and individual harm. Policies cannot be based on the belief that users will always use safely.
3. Policies must be pragmatic, scientifically assessed and based on actual consequences.
4. Users are part of the larger community. Protecting the health of the community as a whole therefore requires protecting the health of users, and this requires integrating users within the community rather than attempting to isolate them from it.

5. Use leads to individual and social harms through many different mechanisms, so a wide range of interventions is needed to address these harms. These include providing health care, including treatment on demand, to current users; reducing the number of persons who are likely to begin using; and enabling users to switch to safer forms of use. (Des Jarlais, 1995)

What are the program and policy issues that need to be addressed to improve the outcomes of current juvenile offenders who have some level of substance use problems?

A beginning point for a response to the question above requires a brief look at beliefs of the roots of juvenile substance abuse and involvement in juvenile crime. In Chasing *Shadows: Confronting Juvenile Violence in America* (Crews and Montgomery, 2001), the authors believe the answers to be complex and involve both nature and nurture. They found that children who experience verbal and physical abuse or neglect during the formative years are more likely to have problems as adolescents. Hence, the stage is set for involvement in juvenile crime when as adolescents they become involved in additional risk factors, such as alcohol and other drugs, gangs or negative adult role models. This is similar to the theory proposed in *Less Hype, More Help: Reducing Juvenile Crime, What Works – and What Doesn't* (Mendel, 2000) in which the author identifies the social development model as a unifying theory to explain why some young people turn to delinquency and why they desist or persist in delinquency over time. The author believes this approach bridges the divide in criminality between the "root causes" theorists who tend to explain criminality as an inevitable consequence of injustice and inequality in society and the "individual responsibility" adherents who place all blame for crime at the hands of offenders by focusing on both the individual and environmental factors with proven connections to juvenile offending. This model is also widely recognized in the substance abuse field, perhaps more so among preventionists than among clinicians, as a framework for policy and program development. The importance of this framework to both systems will be explored in more detail in a later section addressing prevention, but it is important as questions of effective treatment models are explored because it suggests that treatment approaches that fail to recognize and address shared risk factors may not be as effective as those that do. Appendix II, adapted from the Center for Substance Abuse Prevention, illustrates the impact of several risk factors that occur in various areas (or domains) of an individual's life and the relationship of those risk factors to several significant problems facing juveniles today.

Strategies (1999) recommends focusing efforts to improve substance abuse treatment among juvenile offenders in three general areas: philosophy, process and products that reflect the following three guiding principles:

1. the need for substance abuse treatment providers and juvenile justice providers to reshape their views of youthful offenders and their families to a more strengths-based perspective;
2. the importance of providing holistic, effective, culturally relevant and gender-specific substance abuse treatment for youthful offenders; and

3. the importance of working together across systems, not just substance abuse and juvenile justice systems, but the inclusion of faith communities, schools, community-based organizations and providers of health and social services.

In this model, "philosophy" refers to the beliefs and values of individuals and systems that shape policies and programs. Examples include the following philosophies of juvenile justice and adolescent treatment:

Juvenile Justice Models – Gordon Bazemore, in an article on "Young People, Trouble and Crime" (*Youth & Society*, 2001), describes three models of juvenile justice that have dominated program development in recent years. Briefly, these are:

1. The "interventionists" who view the purpose of the juvenile court system as a substitute parent to intervene in the "best interest" of delinquent and troublesome youth. Interventionists tend to assume that the deviant behavior is a symptom of underlying psychological disturbances or deficits.
2. The "libertarians" who view the juvenile justice system as causing more harm than good and may argue that young people involved in minor crimes or substance use, if left alone and not stigmatized, will naturally grow out of this relatively normal and episodic behavior.
3. The "crime control advocates" who view delinquency and youth deviance as a consequence of general permissiveness and the absence of a sufficiently punitive response. The highest priority here is given to suppression and deterrence policies with an emphasis on ensuring that individual offenders receive appropriate punishment.

Bazemore goes on to describe an emerging model that is generally referred to as "restorative justice." From this perspective, the most important factor is the harm caused by the crime and other intentional acts that hurt others. Hence, the focus is on repairing harm to victims, offenders and communities rather than on the individual youth who is in trouble. Policies and programs thus seek to involve the offender, the victim and the community in settings where they interact with the goal of reducing future harm. Adolescents who enter substance abuse treatment are likely to have multiple problems, requiring assessment and intervention beyond the limited focus of their use of substances. Restorative justice approaches view the adolescent as a whole within the context of their family and community. From a juvenile justice perspective, they focus on three questions in the assessment of each case - what is the harm (injustice), what needs to be done to repair it, and who is responsible for this repair? This concept raises an interesting question: Is any use of illicit substances by adolescents in and of itself an injustice or should the focus be on the problems related to use?

Adolescent Treatment Models – Randolph Muck (2001) in his review of the treatment of adolescent substance abuse for *Youth & Society* found four main modalities as follows:

1. The 12-step model, also known as the Minnesota Model or Alcoholics Anonymous (AA) Model, was found to be the most widely used model in the treatment of adolescent drug abusers. It is based on the tenets of AA and views chemical dependency as a disease that must be managed throughout one's life with abstinence as a goal. In addition, many programs include group therapy, individual counseling, lectures, family counseling and recreational activities. Studies of effectiveness

consistently show program completers at six-month and 12-month follow-up had significantly higher rates of abstinence than did the non-completers. However, at two-year post-treatment follow-up, studies do not show significant differences between completers and non-completers.

2. The behavioral treatment model focuses on the underlying cognitive processes, beliefs and environmental cues associated with adolescent use of substances and attempts to teach the adolescent coping skills to help her or him remain drug free. Substance abuse is viewed as a learned behavior; thus, a basic approach in this model is to alter thinking as a way to change behavior. Studies of effectiveness have focused on comparing behavioral models to other treatment methods such as behavioral outpatient with a supportive counseling program. Overall, Muck found studies reported significant decreases in substance use, increased school performance and decreases in depression measures. However, long-range results have not been reported.

3. The family-based treatment model acknowledges the critical influence of the adolescent's family system in the development and maintenance of substance abuse. Treatment techniques are based on four family therapy models – structural, strategic, functional or behavioral – alone or in combination with other models. Family models stress the importance of having the entire "family" present for treatment and seek to find ways to reframe or relabel problem behaviors. Studies of effectiveness have focused on comparing this model to other models of treatment. Results have been mixed but overall family-based treatment models have shown decreases in substance abuse, improved family functioning, improved involvement in school and reductions in peer-associated problem behaviors.

4. The therapeutic community (TC) treatment model is a long-term residential program reserved for adolescents with the most severe substance abuse and related problems. TCs are based on substance abuse being a disorder of the entire person resulting from an interruption in normal personality development and deficits in interpersonal skills and goal attainment. The TC provides a safe, nurturing and structured environment for the adolescent to develop more adaptive personal and social behaviors. TCs for adolescents have been evaluated for effectiveness. Almost half of the adolescents still in treatment halfway through their planned stay show significant positive changes. About 44 percent complete their treatment programs. At 6-month follow-up, there were significant reductions in substance abuse.

Although these four examples are the most frequent models used in the treatment of adolescent substance abuse, they are not necessarily the most effective approaches. In further examining treatment approaches funded by the Center for Substance Abuse Treatment and the Robert Wood Johnson Foundation, Muck (2001) found five approaches that used randomized evaluation and that hold promise for more sustained outcomes. These are:

1. Motivational Enhancement Therapy/Cognitive-Behavioral Therapy (MET/CBT5) Approach, a five-session treatment model with two individual sessions plus three group sessions;

2. CBT7 Approach, which is designed to follow MET/CBT5 by adding two more group sessions;

3. Family Support Network Approach, which is designed as a supplement to MET/CBT with family support such as home visits, parent education and case management;
4. Adolescent Community Reinforcement Approach, which includes 14 sessions with the adolescent and a "concerned other" to focus on learning alternative skills to cope with problems and work on environmental cues; and
5. Multidimensional Family Therapy Approach, a treatment model that integrates substance abuse treatment with 12 weeks of family-focused intervention and additional phone calls and case management.

Integrating effective models of substance abuse treatment among adolescents with juvenile justice systems presents a major challenge. Typically in most states the substance abuse treatment system is under funded and channels its funding to a select set of community providers. Likewise, juvenile justice systems are under funded and tend to focus resources on institutional settings and not community based models. Muck (2001) argues that a new approach is needed wherein there is a commitment to using evidence-based treatment models plus development of systems/infrastructures in communities that can provide better service delivery, continuity of care, earlier engagement in the treatment process and better satisfaction with treatment.

Additional philosophical beliefs that may have an impact on effective treatment among substance-abusing juvenile offenders include the importance placed on gender and culture. The four most common models outlined above are derived from substance abuse treatment among adults. The appropriateness of the content for the youth's age and developmental level has not always been given a great deal of consideration. Likewise, programs do not always consider some of the differences that one's gender and culture have on participation in treatment.

As further discussed in *Strategies* (1999), "process" is the second of the three general areas for consideration in efforts to improve substance abuse treatment for juvenile offenders. This term includes the following four components:

1. a comprehensive needs assessment among providers of youth services to reduce the all-too-often fragmented, overlapping and disjointed systems and programs that attempt to serve youth and their families;
2. a commitment to using evidence-based models to provide more effective services to this population;
3. a commitment among staff at all levels to seek new ways of providing services to youthful substance abusing offenders; and
4. perseverance in the face of bureaucratic and economic barriers to change systems to improve outcomes.

"Product," the third general area for consideration in efforts to improve substance abuse treatment for juvenile offenders, refers to the adoption of new models of service delivery that are carefully planned, based on evidence, and culturally, developmentally and gender appropriate.

Strategies (1999) recommends 15 core components of good practice for substance abuse treatment among juvenile offenders. These are briefly defined as follows:

1. *Use treatment models that are based on research and evaluation as discussed above.*
2. *Conduct comprehensive assessments that evaluate risks, needs, strengths and motivation and that match the youth to appropriate treatment based on the assessment.* Diagnosis of substance abuse or dependence among adolescents is difficult because the validity and reliability of diagnostic criteria are not as clearly established for adolescents as for adults. For example, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) makes no age distinction when defining the difference between dependence and abuse. Obviously, this presents a challenge for clinicians since a diagnosis should not only identify a specific set of behavioral patterns, but it should also predict the prognosis and indicate appropriate treatment options. In addition, the nature of adolescence itself makes it difficult to determine whether substance use is a symptom of a primary illness, an adjustment disorder, a psychiatric disorder or a passing behavioral phase. (Estroff, 2001)
3. *Develop individualized treatment plans.* Treatment planning does not mean just choosing the appropriate treatment program for an individual. For example, the Drug Use Screening Inventory (DUSI) is designed to identify problems related to drug use in 10 domains. These include: substance use; behavior patterns; health status; psychiatric disorders; social skills; family systems; school adjustment; work; peer relationships; and leisure/recreation. Most professionals today recognize the importance of implementing a holistic approach to treatment. This term typically refers to an approach to health care that recognizes the fact that an individual's health is impacted by many factors, including genetics, nutrition, physical activity, living and working conditions, stress, access to medical care, and socioeconomic status. Holistic programs emphasize prevention of problems and the individual's responsibility for managing his or her own health care. Thus, in a holistic approach, adolescents are less likely to be seen as patients and more likely to be seen as consumers who are capable of participating in their own treatment.
4. *Provide case management that is across systems and time.* The substance abuse system has a tradition of confidentiality that is reinforced by federal laws. The juvenile justice system also has a long tradition of protecting the confidentiality of minors under the age of 18. This further complicates the integration of programming in communities where the juvenile justice system and the substance abuse treatment system are separate. This lack of integration can present problems in developing assessments that can guide case managers, developing service plans to alleviate risk factors and linking with other providers of youth services.
5. *Involve the adolescent's family in all aspects of treatment.* Most providers would probably say this is easier said than done, perhaps because of the logistics of doing so, as well as the lack of motivation on the part of the adolescent's family.
6. *Provide a system of care that encompasses a youth's transition from institutions to community.* In some ways, substance abuse treatment within an institution presents a "safe" environment. The challenge occurs when the adolescent returns to her or his community.

7. *Build support for treatment at the institutional and community levels.* Substance abuse treatment frequently is among the programs that are cut as federal and state budgets are reduced to meet economic needs. Although supported by evidence, this is not enough to ensure the sustainability of programs that work.
8. *Develop interagency collaboration with other youth service providers to provide holistic treatment and recovery.*
9. *Provide interdisciplinary cross training.* If beliefs and models were the same for the juvenile justice system and the substance abuse treatment system, training could take the form of distributing manuals. However, words continue to have different meanings for workers from both systems.
10. *Take special care in the recruitment, selection, evaluation and retention of staff.*
11. *Build evaluation into every aspect of the program and use findings to improve performance.*
12. *Implement management information systems that can be used across systems.*
13. *Conduct cost benefit analyses and other quality improvement activities to maximize use of resources.*
14. *Develop and use a strategic plan.* The Robert Wood Johnson Foundation in its grant program, Reclaiming Futures, has singled this out as one of the most important components of successful collaborations among juvenile justice and substance abuse treatment providers.
15. *Implement a quality assurance system.*

Although not specifically cited in the above 15 core components recommended in *Strategies* (1999), female adolescent substance abusers present different issues than do male adolescent substance abusers. In recent years, many substance abuse treatment professionals have advocated for female-sensitive treatment that recognizes the fact that women respond differently than men. This conceptual approach recognizes that females are not a homogenous group and that race and/or ethnicity, pregnancy, choice of drug used, age and marital status all represent subtypes of substance using and abusing females. Unfortunately, there has been little information about effective addiction treatment strategies for women and even less for female adolescents because both have been underrepresented in studies. There is evidence that some women may be more responsive than men to certain treatment approaches. Psychosocial and behavioral approaches may be more effective with women than with men because of differences in self-esteem. There is evidence that the confrontational style of treatment is not an effective approach with women in general. Women substance abusers tend to have higher rates of mood and anxiety disorders than men and lower self-esteem. In addition, women frequently have child-care responsibilities that interfere with participation in treatment and often lack marketable employment skills thus lessening chances of recovery. The incidence of women in treatment who report sexual or physical abuse is very high and poses issues such as: how well assessment instruments identify sexual or physical abuse; separation of males and females in treatment settings; and providing additional services for women who are in need because of sexual or physical abuse. (Murphy and Rosenbaum, 1999) In addition, perinatal substance abuse on the part of females, mostly because of the attention given by the media to the use of cocaine and crack cocaine, has seen a

proliferation of controversial interventions, including a variety of legal attempts to detect perinatal substance abuse and force pregnant or postpartum women into drug-free conditions. Such laws have directly affected all the fields of child welfare, justice, medicine and addictions treatment. For example, in South Carolina, a viable fetus can be considered a person under the child abuse and neglect statute; thus, a pregnant female may be held criminally liable for any action during her pregnancy that would "endanger the life, health or comfort" of her fetus. In South Dakota, a women who is found to be using drugs or drinking heavily during pregnancy can be held in a treatment center for her entire pregnancy. In Wisconsin, women in the third trimester of pregnancy can be confined until they give birth. (Szalavitz, 1998)

In addition, the above 15 core components do not address options for addressing adolescents who do not respond to substance abuse treatment. Untreatable substance abusing adolescents do exist. However, in the substance abuse treatment field, many providers do not want to talk about untreatable abusers. Major reasons for classifying adolescents as untreatable include severe sociopathy/personality disorder, severe oppositional defiant behavior, and not wanting to stop abusing as well as parental factors such as lack of commitment and/or sabotage. However, substance abuse treatment programs working with youth who enter through the juvenile justice system are confronted with the unique challenge of identifying those who view treatment as a way to bide their time or to slide through the system in addition to the above disorders. Programs confronted with these adolescents should never discharge in haste or anger and must recognize the need for the youth to be in a safe environment. Thus, what to do with adolescents who may fall into this category is a significant problem. (Estroff, 2001)

What are the evidence-based programs and strategies needed to prevent substance use among juvenile offenders?

> *"Would you tell me please which way I ought to go from here?" asked Alice. "That depends a good deal on where you want to get to," said the cat. "I don't much care where," said Alice. "Then it doesn't matter which way you go," said the cat*. Lewis Carroll

Unlike Alice, providers of substance abuse and juvenile crime prevention now have available a body of research and practice knowledge that can assist them in determining where they want to go and the best approaches to use to get there. However, without a framework for the selection, delivery and assessment of programs and practices, providers of prevention are frequently, like Alice, unsure of the direction they want to take. The result is that prevention efforts are not performance-based and frequently do not result in a decrease in the problems caused by the use of alcohol, nicotine and other drugs. These problems are complex and unfortunately are not solved by simple solutions. Having a prevention framework that is performance-based gives prevention providers tools for identifying needs, selecting and planning programs and practices, implementing programs, and measuring their outcomes.

Why are some programs more successful than others in reducing the problems that result from the use of alcohol, nicotine and other drugs among youth and/or adults or in preventing or delaying the onset of use of these substances by children and youth? Perhaps the most frequent answer given is a lack of funding to adequately implement prevention programs.

While this is rightfully a major concern, since substance abuse prevention funding seemingly is not a funding priority at the community, state or federal levels of government or private organizations, it does not completely answer this question since there are numerous examples of well-funded programs that have not shown significant results. Perhaps some of the answers can be found in how well prevention providers apply the lessons learned from past efforts. These include:

1. using evidence-based theories and programs that meet at least a Level 3 standard (see definition on next page);
2. blending evidence-based individual (host) and environmental (policy) approaches;
3. using a process to identify the intervening variable(s) that have an impact on the risk and/or protective factors identified through a needs assessment that is evidence-based;
4. using a logic model to plan, implement and evaluate the outcomes of the program; and
5. being part of a larger prevention resource system.

The remainder of this paper will examine these five key performance indicators from the perspective of substance abuse prevention and will leave it to Leadership Institute participants to determine whether these factors can be applied equally to efforts to prevent crimes among juveniles.

1. *Using evidence-based theories and programs that meet at least a Level 3 standard.*

   The first key to developing a performance-based prevention framework begins with commitment: first by the heart and second by the head. The commitment from the heart is a passion to change the current level of problems caused by the use of alcohol, nicotine and other drugs. If you do not want to see things change, then chances are your commitment to prevention will not be lasting. Preventionists are change agents who are committed to working for changes that may not be seen for years.

   A commitment to change, however, is not enough. From the head, there must be a willingness to apply the lessons learned from theories and programs that have been shown to be science-based, research-based or evidence-based. Why? Because the use of evidence-based theories or programs increases the likelihood that the interventions selected will have a greater probability of success. This is a critical step that many prevention providers find difficult to take, because it can mean forsaking familiar programs for other approaches that may require learning a new set of decision making skills, in addition to making a new or altered commitment of resources.

   Evidence-based refers to the process by which experts use commonly agreed-upon criteria to assess the outcomes of an intervention to reach consensus that the findings are credible and can be substantiated. It begins with the question: "*What is the probability (i.e., the level of evidence) that this intervention will have results with this problem among the identified target population?*" The Center for Substance Abuse Prevention recommends that substance abuse prevention providers determine the level of evidence that best meets their needs through applying five types of scientific review processes. Briefly these are as follows:

Level 1: Programs at this level have been identified or recognized publicly, received awards, honors or mentions. At this level, however, there is not sufficient evidence to ensure that the intervention is effective.

Level 2: Programs at this level have appeared in a non-refereed professional publication or journal. At this level, there is suggestive value but professional journals do not have the same standards for expert review by peers, as do peer-reviewed journals.

Level 3: Programs at this level have documented outcomes that have been subjected to thorough scrutiny by an expert/peer consensus process for the quality of implementation and evaluation methods and/or appeared in a peer-reviewed journal. Many substance abuse prevention providers recognize this level of programming as the minimum acceptable level for the programs they select for implementation. At this level, the cautious substance abuse provider will still closely examine how well the program's activities are suited for the setting and the identified target population before implementing the program.

Level 4: Programs at this level have undergone an expert/peer process of qualitative and/or quantitative meta-analysis. At this level, multiple studies show consistently positive conclusions.

Level 5: Programs at this level have resulted in replication in other settings and have appeared in several refereed professional journals. The best level of evidence of a program's effectiveness is that it can be replicated across settings and populations.

2. *Blending evidence-based individual (host) and environmental (policy) approaches.*

In *Alcohol and the Community: A Systems Approach to Prevention*, author Harold Holder presents a compelling argument that drinking alcohol is not only a personal choice frequently driven by biological factors, but it is also a matter of custom and social behavior within an individual's specific community that is influenced by access and economic factors, such as the level of disposable income and the cost of alcoholic beverages. Thus, the more promising prevention approaches will adapt an ecological perspective of the community and the role of substances within the community. Holder encourages prevention providers to incorporate the following propositions into a new paradigm for preventing alcohol problems or problems resulting from the use of tobacco and other drugs:

- Substance abuse problems are the natural result of dynamic, complex and adaptive systems called "communities";
- Intervening only with high-risk individuals or small groups can produce short-term reductions in substance abuse, but the system will produce replacements for individuals who leave high-risk status, and the system will adapt to changes in the compositions and behavior of its subgroups and populations;
- The most effective prevention programs will incorporate strategies to alter the system (community) that produces substance abuse;

- Prevention programs have historically been "single focused"; that is, they have attempted to accomplish a goal by one program or strategy rather than by concurrent, mutually reinforcing approaches; and
- Without an understanding of the community as a dynamic system, that is, without a model that increases our ability to understand and effectively change the system, it is unlikely that effective long-term prevention will occur.

Individual approaches to substance abuse prevention define the problem as one of poor decision making by individuals. Health is seen as a personal concern and prevention approaches are directed at improving decision making or resistance skills. Individual approaches are critical to successful prevention programs, especially those that target small groups of individuals or high-risk populations. However, a focus only on individual approaches causes prevention providers to be one dimensional in their efforts.

Environmental approaches to substance abuse prevention define the problem at the policy level. Health is seen as a social issue and prevention approaches are directed at changing public laws, policies and practices to create environments that decrease the probability of substance abuse.

The challenge to prevention providers is to first become two dimensional in conceptualizing approaches to prevention and second to blend these approaches in order to maximize outcomes.

A two-dimensional approach to prevention can be illustrated by the following:

Individual	Environmental
- define individual problems that place a person at-risk	- define problems at the policy level
- substance use is seen as a personal choice	- substance use is seen as both an individual and a systems issue
- approaches consist of short-term programs	- approaches involve long-term policy changes
- programs are used to change individual behavior	- strategies are used to influence changes in policies

Prevention providers should avoid "choosing sides," that is, becoming an advocate for an environmental approach over an individual approach or vice versa but should rely instead upon the research to guide them in the selection of an appropriate blend of individual and environmental approaches. For example, most schools, colleges and communities are concerned about the use of alcoholic beverages by persons under the age of 21. The 1999 publication of the Office of Juvenile Justice and Delinquency Prevention, titled *Strategies to Reduce Underage Alcohol Use: Typology and Brief Overview,* reviews 36 approaches to prevent underage drinking and ranks the research evidence on the outcomes of each. School-based curricula rank low in terms of measurable outcomes on changing underage drinking behavior. A one-dimensional prevention provider who advocates only approaches that are intended to provide the individual with health decision-making skills may erroneously choose a school-based curricula as the approach to reduce underage drinking. A two-dimensional prevention provider will not only choose individual

evidence-based approaches but will also implement environmental approaches that have proven to be highly effective, such as compliance checks, zero tolerance laws and increases in the cost of alcoholic beverages.

An article by Michael Klitzner in the January/February 1999 edition of *Prevention Pipeline,* titled "Integrating Environmental Change Theory into Prevention Practice," provides practical strategies for implementing prevention policy changes.

Since few prevention practitioners receive training on substance abuse prevention theory prior to coming to their work, understanding the theories supporting individual behavior changes and those supporting environmental system changes need to be part of their in-service education. However, a significant challenge to prevention providers is devoting the time and the resources to stay current with the research on what works and why. Thanks to the Internet, this information is becoming increasingly accessible to prevention practitioners, although few Internet sites devote the time required to review the research literature in order to produce up-to-date summaries of lessons learned. In addition, federal agencies such as the Center for Substance Abuse Prevention occasionally produce documents or conduct videoconferences on lessons learned from science. State clearinghouses on alcohol, tobacco and other drugs usually subscribe to the journals in which the research is published but seldom have the resources to synthesize the information in a form that is useful to prevention providers.

3. *Using a process to identify the intervening variable(s) that have an impact on the risk and/or protective factors identified through a needs assessment that is evidence-based.*

Research and practice plus common sense combine to tell us over and over again that interventions need to be mutually reinforcing and concurrent within the school, family, media, workplace and community to maximize effectiveness. For example, as in the previous illustration, if an assessment of needs indicates that underage drinking is a significant problem in community "X," and the community decides to set a goal of reducing underage drinking, all of the strategies and programs initiated should be designed to reach this goal. Some of the approaches may target the individual behavior of youth through school-based programs that focus on life skills training or through peer initiatives such as developed in many states through the Teen Institute model or similar programs, while other approaches target reducing access to alcohol through compliance checks, merchant education or keg registration. However, accomplishing this level of comprehensive planning is perhaps the greatest challenge facing prevention practitioners at all levels. Among the challenges are the following:

- *A lack of clarity and support on the part of community leaders of effective prevention strategies.* Informing key decision-makers about what works and why is an ongoing task for prevention providers.

- *The fragmentation of efforts at the federal and state levels that has an impact on commitments to systems collaboration at the community level.* Federal funding for substance abuse prevention comes to the states from several different agencies that in turn distribute funding through their systems. At the community level, the recipients

of these funds are told of the need to collaborate; however, this recommendation is typically not modeled at the state and federal levels. In addition, collaboration requires the flexibility to blend funding to meet local needs. This level of flexibility is seldom granted to communities. Agencies and organizations at the state and community levels must place a value on developing prevention resource systems that are intentional in their linkages and funding.

- A *lack of knowledge of risk and protective factors that correlate with the needs identified through an assessment and that can be used to develop a community risk and protective factor profile, therefore guiding the selection of goals, objectives, strategies and activities.* Thanks to David Hawkins and others, prevention providers now recognize the need to target both risk and protective factors. As a field, however, we are still learning which risk factors, such as easy access to substances, family members with a history of substance abuse or poor academic achievement, pose a greater risk than others. In other words, not all risk factors are equal. Nor are all protective factors equal. Hence, whether the approach is to decrease risk or build upon protective assets or preferably to blend approaches, the prevention planner must be able to apply the lessons learned from research and practice in selecting the risk and protective factors to be targeted and the most effective interventions. Not all interventions will equally impact identified risk and protective factors. Therefore, careful planning of the interventions identified is needed to maximize outcomes. Based on the review of the juvenile crime prevention literature for this paper, there appears to be a greater focus on programming that attempts to enhance protective factors than on a balanced approach that emphasizes both risk and protective factors. Thus, prevention providers from substance abuse systems and those from juvenile justice systems may frequently find themselves struggling to determine which approaches will be the most effective with youthful offenders.

  Experiences as validated by research during the past decade have proven that a balanced risk and protective factor framework holds the most promise for reducing substance abuse among youth. Within this framework, risk factors are "those characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected from the general population, will develop a disorder." Protective factors are "those factors that mediate or moderate the effect of exposure to risk factors, resulting in reduced incidence of the problem behavior." (Pollard, Hawkins and Arthur, 1999)

  As one of the early advocates of this framework, Bonnie Bernard recommended that substance abuse should be framed within "a developmental context" where the goal is to create "socially competent people who have a sense of their own identity and autonomy, which are able to make decisions, set goals and believe in their own future." (Bernard, 1995)

  In June 1996, the National Institute on Drug Abuse (NIDA) reported findings from a study that identified a number of protective factors that appeared to influence some youths' decisions about engaging in delinquency or substance abuse. NIDA's study found that having protective factors in multiple domains, such as family, school, peers

and neighborhoods, appeared to buffer some adolescents from factors that placed them at risk. Among those protective factors were: parental supervision, child's attachment to parent, parent's attachment to child, reading percentile, mathematics percentile, commitment to school, attachment to teachers, parent's expectation for child to go to college, parent's values about college, peers having conventional values, and parent's positive evaluation of peers. Characteristics that some prevention providers assumed were important, such as self-esteem, were not strong predictors of resistance to decisions about engaging in substance use or delinquency. Most importantly, this study found that youth with six or more protective factors were almost three times as likley to remain substance abuse free over a three-year period as youth who had three or fewer protective factors.

More recently, the National Institute on Alcohol Abuse and Alcoholism convened a panel of scientists to address how to keep kids alcohol free. This panel, using the evidence from years of research and experience, concluded that the following three strategies had the most evidence of success:

- reducing the availability of alcohol;
- improving the effectiveness of law enforcement; and
- changing social norms.

Examples of evidence-based activities for these strategies include:

- raising the price of alcoholic beverages;
- controlling the number of alcohol outlets;
- training servers of alcoholic beverages;
- conducting compliance checks;
- regulating home delivery of alcohol; and
- eliminating alcohol promotions designed to appeal to children. (*Keep Kids Alcohol Free: Strategies for Action*, 2001)

The conclusion drawn by many substance abuse researchers, providers and policy makers is that approaches to prevention that rely solely on enhancing protective factors may overlook the growing body of research that indicates policy changes in the environment are the more promising approaches to reducing use. Appendix III, adapted from the Center for Substance Abuse Prevention, provides an illustration of the risk and protective factor framework.

- *The tendency to make one program "fit" everyone.* This is most evident when prevention providers fail to understand how risk and protective factors may differ across racial and ethnic populations. For example, there are ethnic differences in the relative effects of peers and arrests on substance use behavior. Numerous studies as reported by Braithwaite and Taylor (2001) in *Health Issues in the Black Community* have found that peers exert a stronger influence on cigarette and other drug use among whites and Hispanics than among African Americans. Conversely, parents appear to have a greater impact on substance use among African Americans than among white youths. Using this information, a program to prevent use of tobacco products among African American youth based on a peer model may not be as successful as hoped.

- *A lack of commitment on the part of prevention providers to utilize strategic planning to improve prevention efforts.* Many states and communities have developed some form of a strategy to prevent substance abuse. Some have utilized the risk and protective factor information to develop a profile that is used to determine priorities for prevention efforts and in addition can be used to determine which risk or protective factors to target. In addition, many states and communities have developed goals and objectives that support the national ones set by the U.S. Secretary of Health and Human Services. However, the substance abuse prevention system as a whole has not adequately supported planning as a major function of prevention practitioners. State and community agencies must place a value on developing comprehensive prevention strategies and plans.

- *A low level of commitment on the part of prevention programs to confront the norms or laws within their state or community that promote easy access to alcohol, tobacco or other drugs or that promote use of these substances.*

4. *Using a logic model to plan, implement and evaluate the outcomes of the program.*

   A logic model of planning means that a program or intervention follows a logical design. Most descriptions of logic models have the following components in common:
   - planning begins with an assessment of the needs and assets of a population or a community;
   - program strategies and practices are grounded in clearly stated goals and objectives;
   - program strategies and activities are based on science-based theories and models; and
   - efforts are evaluated with a built-in feedback loop to further improve outcomes.

   Every prevention program should originate from some form of a needs assessment that provides guidance in answering the question: "What are the problems resulting from substance abuse in this target population, and how do we know it is a problem?" For substance abuse prevention program planners, this means gathering information on prevalence rates, who uses what and how much, and problem indicators such as arrest rates, crash data, morbidity and mortality reports, etc. From the survey and archival data gathered, the prevention planner can determine which risk and/or protective factors to target.

   Abe Wandersman and his colleagues have identified 10 basic accountability questions that experience has shown to be a key to successful prevention programs, as they help to assess the appropriateness of the logic model for the program design. These questions are examined in some detail in *The Journal of Primary Prevention*, Volume 19, Number 1, Fall 1998, and further expanded in *Getting To Outcomes: Methods and Tools for Planning, Evaluation and Accountability* (GTO), a guidebook to help practitioners plan, implement and evaluate their science-based programs and strategies to achieve results. GTO is based on answering the 10 accountability questions about needs and resources, goals, science and best practices, fit, capacity, plan, implementation, outcome evaluation, continuous quality improvement, and sustainability. (Wandersman, et.al., 2000) The 10 questions used in the GTO model are presented below:

1. What are the underlying needs and conditions that must be addressed?
2. What are the goals, target populations and objectives (i.e., desired outcomes)?
3. Which science (evidence)-based models and best-practice programs can be useful in reaching the goals?
4. What actions need to be taken so the selected program "fits" the community context?
5. What organizational capacities are needed to implement the program?
6. What is the plan for this program?
7. How will the quality of program/initiative implementation be assessed?
8. How well did the program work?
9. How will continuous quality improvement strategies be incorporated?
10. If the program is successful, how will it be sustained?

Learning organizations place a value on creating, acquiring and transferring knowledge and at modifying programs to reflect new knowledge and insights. In other words, if prevention program providers continue to do things the same way, then the organization can expect to get the same performance. Using a logic model of program development and application assists in reducing the likelihood that efforts are based on faulty theories and programs and that the organization will value learning ways to improve.

5. Being part of a larger prevention resource system.

Every state and territory, and hopefully individual communities, benefit from federal funding intended to create or sustain programs to reduce the demand for alcohol, nicotine or other drugs. In addition, many states have received funding through legislation or special appropriations to develop substance abuse prevention programs.

Federal funds coming to the states for substance abuse prevention go to a number of different agencies depending on the structure of a particular state's government. Frequently referred to as "stovepipe" funding, these funds have traditionally gone to the state equivalent of the federal agency administering the funds. For example: Substance Abuse Prevention and Treatment Block Grant funds go to the Governor's designated single state authority for alcohol and drug abuse; Safe and Drug-Free Schools and Communities funds for the most part go to state departments of education; Byrne Formula Grant Program funds go to public safety; and CDC funds for tobacco prevention go to public health agencies. While these federal funds often carry the recommendation to coordinate with other agencies that have an interest and/or investment in similar programming, for example, substance abuse prevention, such collaboration does not always occur.

Perhaps the most negative outcome of the "stovepipe" approach has been the tendency of the administering organizations at the state level to become so caught up in the mission dictated by their funding source that they operate as if they are unaware of the interrelationships among major health and social problems such as those involving substance abuse. Organizations that focus on a single problem and operate in such a manner frequently fail to value communication, coordination and collaboration as a way of doing business. In addition, the value of collaboration is not modeled so that it is seen at the community level as the way to plan and implement programs.

In recent years, there has been a trend toward substance abuse prevention funding going to a state's governor in an effort to increase effectiveness. In addition, some states have created coordinating organizations, either voluntarily because of the recognition of the value of a collaborative systems approach to prevention, through legislation or by executive order of their governor, in an effort to minimize the negative aspects of "stovepipe" funding and to maximize collaboration.

A collaborative systems approach to substance abuse prevention is supported by research that recognizes the interrelationships that exist among high-risk and/or addictive behaviors and by the experience of prevention planners who have created outstanding programs but have seen these "chimneys of excellence" wither over time as funding or priorities changed. The defining characteristic of a system is that it cannot be understood as a function of its isolated components. The behavior of the system does not depend on what each part is doing but on how each part is interacting with the rest. For example, a car's engine may be working just fine, but if the transmission is missing, the car will not move. Collaboration has become a standard mandate in funding guidelines from federal and state agencies. However, the active practice of collaboration appears far too frequently to be one of those things that funding sources impose on communities and fail to adequately practice at the state and federal levels for a myriad of excuses ranging from legislative mandates to not enough time. If communities are to be successful in reducing the problems caused by alcohol, nicotine and other drugs and/or juvenile crime, it is time to move away from a "stovepipe" mentality and begin to actively develop national, state and community prevention resource systems. A prevention resource system is a conscious, intentional linkage among all agencies and organizations that have a mandate to deliver substance abuse prevention to collaboratively promote science-based prevention through planning, funding, training and evaluation of outcomes.

Mike Lowther, the director of the Southwest Center for the Application of Prevention Technologies and its predecessor, the Southwest Center for Drug-Free Schools and Communities, have been pioneers in facilitating the development of the functions of prevention resource systems. Once functions are identified, these provide a useful tool for prevention planners to assess the level of system development or "community readiness," as it is frequently referred. Among the functions identified by Lowther and others who have been interested in systems development are the following:

1. Intentional Networking – There exists a network of agencies and organizations with a mandate to deliver substance abuse prevention that meet on a frequent basis. In addition, there exists a channel of communication among state and community prevention resource systems that provides input on policies and programs.
2. Collaboration – The agencies and organizations value and model learning together how to improve substance abuse prevention. Leadership is shared among all members of the system. Approaches, plans, policies, programs and evaluations are an outcome of this process.
3. Conceptual Clarity – The agencies and organizations have reached consensus on a definition of substance abuse prevention and developed a statement of "best practices"

based on lessons learned from research. Plans, policies, programs and outcomes reflect the consensus definition and "best practices."

4. Strategic Planning – The agencies and organizations have developed an approach based on principles of strategic planning (input from customers, needs assessment based on data indicating substance abuse, approaches based on science-based prevention, etc.) and disseminated the strategic plan. The plan is followed by all state or community agencies and organizations with a mandate to do substance abuse prevention and is routinely updated to reflect lessons learned.
5. Policy Development – Policies are consistent with the strategic plan and support evidence-based prevention approaches.
6. Evaluation – A consistent approach to measuring the outcome of policies and programs based on the strategic plan and lessons learned from research is used by all the state agencies and organizations. Lessons learned are used to improve performance.
7. Funding Commitment – A commitment exists on the part of the agencies and organizations to provide funding and to leverage funding to fill gaps based on needs assessments as part of the strategic planning and lessons learned from research.
8. Program Models – The agencies and organizations agree on criteria for evidence-based program models and disseminate this criteria and program models.
9. Technical Assistance – The agencies and organizations have a process for the acquisition or delivery of technical assistance to communities that models the collaborative nature of the prevention resource system.
10. Education and Training – The agencies and organizations collaborate on multiple approaches to disseminating information on prevention technology and in providing training at the community level. Mechanisms exist to update information dissemination and training as needed.
11. Cultural Competency and Inclusion – The prevention resource system models cultural competency and inclusion at all levels of activity and programming.
12. Marketing and Recognition – There exists a process for informing the general public, customers and key decision makers of the existence of the state prevention resource system and of the successful outcomes of prevention policies and programs.

Summary

If the prevention and treatment of adolescent substance use, abuse or dependence was easy, there would be no need for forums such as these. The same is true for efforts to prevent crime by juveniles. Bly (1996) helps us to visualize the problem by imagining a field in which all adolescents are on one side of a line drawn on the earth and adults are on the other side looking into their eyes. In an earlier time, there were strong adult role models, such as Martin Luther King, Lou Gehrig, Madame Curie, respected teachers, coaches, preachers untouched by scandal, older men and women in every community, who were capable of drawing the young people over the line into adulthood by their very example. Now, adolescents look to their own unless adults are willing to walk up to the line and help today's young people cross the growing divide between adolescence and adulthood. If today's adults remain unwilling or unable to help our society's young people, these individuals will stay exactly where they are for another 20 or 30 years. Hence, it's up to the adults to find ways to step up to the line and offer a hand.

References

Bazemore, G. "Young People, Trouble, and Crime." *Youth & Society*, Vol. 33, No. 2, December 2001.

Bernard, B. "Application of Resiliency: Possibilities and Promise" presented at the Eighth Annual National Prevention Network Research Findings Conference, Stevenson, WA. 1995.

Braithwaite, R. and Taylor, S. *Health Issues in the Black Community.* Jossey-Bass Publishers, San Francisco, CA. 2001.

Bly, R. *The Sibling Society.* Addison-Wesley Publishing Company, New York, NY. 1996.

Crews, G. and Montgomery, R. *Chasing Shadows: Confronting Juvenile Violence in America.* Prentice Hall, Upper Saddle River, NJ. 2001.

Des Jarlais, D.C. Editorial: "Harm Reduction – A Framework for Incorporating Science into Drug Policy." *American Journal of Public Health*, Vol. 85, No. 1, January 1995.

Duncan, D.F., et.al. "Harm Reduction: An Emerging New Paradigm for Drug Education." *Journal of Drug Education*, Vol. 24, 1994.

Estroff, T.W., ed. *Manual of Adolescent Substance Abuse Treatment*. American Psychiatric Publishing Inc., Washington, DC. 2001.

Garvin, D. "Building a Learning Organization." *Harvard Business Review*, July-August 1993.

Holder, H. *Alcohol and the Community: A Systems Approach to Prevention.* Cambridge University Press, New York, NY. 1998.

Keep Kids Alcohol Free: Strategies for Action. National Institutes for Health, 2001.

Klitzner, M. "Integrating Environmental Change Theory into Prevention Practice." *Prevention Pipeline*, January/February 1999.

Koffman, F. and Senge, P. "Communities of Commitment: The Heart of Learning Organizations." *Organizational Dynamics*, Autumn 1993.

Kretzmann, J. and McKnight, J. *Building Communities From the Inside Out*. ACTA Publications, Chicago, IL. 1993.

Mathias, R. "Protective Factors Can Buffer High-Risk Youths from Drug Use." *NIDA Notes*, Vol. 11, No. 3, May/June 1996.

Mendel, R. *Less Hype, More Help: Reducing Juvenile Crime, What Works – and What Doesn't.* American Youth Policy Forum, 2000.

Muck, R., et.al. "An Overview of the Effectiveness of Adolescent Substance Abuse Treatment Models." *Youth & Society*, Vol. 33, No.2, December 2001.

Murphy, S. and Rosenbaum, B. *Pregnant Women on Drugs: Combating Stereotypes and Stigma.* Rutgers University Press, New Brunswick, NJ. 1999.

Pollard, J., Hawkins, D., and Arthur, M. "Risk and Protection: Are both necessary to understand diverse behavioral outcomes in adolescence?" *Social Work Research,* Vol. 23, No. 3, September 1999.

Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide. Center for Substance Abuse Treatment, U.S. Department of Health and Human Services. June 1999.

Strategies to Reduce Underage Alcohol Use: Typology and Brief Overview, U. S. Office of Juvenile Justice and Delinquency Prevention, 1999.

Szalavitz, M. "War on Drugs, War on Women." *The Issues Magazine*, Winter 1998.

Wandersman, A., et.al. "Comprehensive Quality Programming and Accountability: Eight Essential Strategies for Implementing Successful Prevention Programs." *Journal of Primary Prevention,* Vol. 19, No. 1, Fall 1998.

Wandersman, A., et.al. *Getting to Outcomes: Methods and Tools for Planning, Evaluation and Accountability*, Center for Substance Abuse Prevention, U.S. Department of Health and Human Services, 2000.

"Bringing Restorative Justice to Adolescent Substance Abuse." *Youth & Society*, Vol. 33, No. 2, December 2001.

About the Authors

Jim Neal has served as the director of the Leadership Institute since its inception in 1994. He retired in 1996 from the South Carolina Department of Alcohol and Other Drug Abuse Services after more than 32 years of service and now spends his time trying to understand "what works" in substance abuse prevention and treatment. He is employed part-time by the Pacific Institute for Research and Evaluation; the School of Public Health at the University of South Carolina; and the Southeastern Conference on Alcohol and Other Drug Programs Inc.

Kimberly N. Sutton, Ph.D., is an associate professor in the Department of Psychiatry and the director of the Cork Institute on Black Alcohol and Other Drug Abuse at the Morehouse School of Medicine. Research activities past and present include depression, suicidal ideation and eating disorders. She was the site director for ADAM, the Arrestee Drug Abuse Monitoring Project, sponsored by the National Institute of Justice and is the principal investigator for the Southeast Addiction Technology Transfer Center. She has presented locally, nationally and internationally on topics such as addiction, domestic violence, and mood and personality disorders and has facilitated various workshops. She serves on various institutional and civic committees and has received teaching awards in the field of psychology.

Group Consensus

The keynote panel presentation and background paper titled *"Substance Abuse Among Juvenile Offenders: Policy Issues for Prevention and Treatment"* raised numerous key issues for dialogue among the participants of the Leadership Institute. For the purpose of dialogue, the key issues were broken down into two general areas: (1) policy issues for the treatment of substance abuse among juvenile offenders; and (2) policy issues for the prevention of substance abuse among juvenile offenders.

Following is the group's consensus on key issues that fall within each of these two categories, and where identified, the group's recommendations for action.

Policy Issues for the Treatment of Substance Abuse Among Juvenile Offenders

Participants began their dialogue on this issue by reaching consensus on several fundamental issues as identified by the following questions.

Question 1: What are the problems of labeling any use of alcohol, nicotine or other drugs by young people as "abuse"? What are the benefits? How do these two perspectives influence substance abuse treatment policies? How do they influence juvenile justice policies?

Participants began their dialogue by reaching conceptual clarity on the many problems and benefits of labeling any non-medical use of psychoactive substances among adolescents as "abuse." For example, they agreed that the word "abuse" presents a negative connotation or stigma that could limit treatment options for adolescents. Participants also recognized that this term does not apply equally to all levels of adolescent substance use. Despite these problems, however, participants also identified several benefits to using this term. Specifically, they felt that the "abuse" label might assist service providers in the early detection of problems among adolescents who might be predisposed to more severe problems because of their family history of dependence. In addition, the use of the term "abuse" also helps to establish clear boundaries between acceptable and unacceptable behaviors, as well as to increase the visibility of this issue, which could possibly result in increased funding for services to address this problem.

Participants strongly encouraged the integration of services between the juvenile justice system and the substance abuse treatment system, beginning at the state level, in an effort to avoid the fragmentation and/or the duplication of services for adolescents and to offer a wider range of appropriate services. Participants also recommended that the two systems should adopt a common language that differentiates between use, abuse and dependence in order to conduct more thorough and appropriate assessments and referrals of juvenile offenders. Participants further recommended that the state substance abuse and juvenile justice agencies should develop interagency training for their respective service providers to enhance their knowledge and understanding of the problems of adolescent substance use/abuse/dependence.

Of particular concern to the participants was the inadequacy of the diagnostic criteria that are currently available for the treatment of adolescent substance abusers. Specifically, they felt that the diagnostic options included in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), a publication of the American Psychiatric Association, are often inappropriate for use with children and adolescents and can lead to inappropriate

diagnoses. For this reason, participants strongly recommended that the Association should develop and publish a separate diagnostic manual for this population, for example, the "Diagnostic and Statistical Manual of Juvenile Disorders." At a minimum, the participants encouraged the Association to include separate criteria for this population in its new DSM-V that would place particular emphasis on specific characteristics such as age and developmental levels.

Participants further recommended that state substance abuse and juvenile justice agencies should develop a mutually acceptable screening and diagnostic tool that is unique to the adolescent population, in addition to the tools they currently use with adults. Participants also encouraged all service providers to recognize that a continuum of use exists, beginning with "no use" and progressing through "use, abuse and dependence." Participants agreed that the use of psychoactive substances among adolescents should not be treated by either system as "an adolescent rite of passage" or as "casual or experimental" use. Participants recognized that any use of psychoactive substances could: (1) trigger a major threat to health and safety, such as driving under the influence, family disputes, etc.; and/or (2) signal an adolescent's involvement in other high-risk behaviors. Participants expressed concern about the lack of clarity among society in general about what is expected as "normal" behavior among adolescents. Participants agreed that society should set clear norms and expectations regarding adolescent substance use that recognize the potential dangers that any level of use of psychoactive substances can pose to the individual, the family and society as a whole.

Question 2: Review the basic principles of harm reduction as presented in the background paper. Which, if any, of these principles can be incorporated into policies for treating adolescent substance abusers? How compatible are harm reduction principles with juvenile justice principles?

Participants reviewed the five basic principles of harm reduction as presented in the background paper and reached general agreement about the characteristics of this approach. However, they recommended that "no use" of any psychoactive substance should be the goal of all substance abuse prevention and treatment programs targeting this population. Participants felt that harm reduction approaches are not particularly compatible with the approaches used by the juvenile justice system. Specifically, they felt that the juvenile justice system's need to carry out penalties as mandated by state and/or federal laws would limit the application of harm reduction approaches because these approaches emphasize the prevention of harm to the user and society rather than addressing the legal consequences of drug use and/or possession. Participants explored a variety of harm reduction approaches that could be incorporated into substance abuse treatment for adolescents. Among these include: (1) adapting the language of harm reduction so as to address treatment consequences rather than criminal consequences for continued use; (2) linking the adolescent with an array of services within the community based upon the individual's needs; and (3) applying harm reduction strategies to approaches to reduce resistance to the stages of change among substance-abusing adolescents.

Question 3: Is there conceptual clarity of the term "restorative justice"? What are the pros and cons of applying this model to adolescents who are in need of substance abuse treatment?

Participants viewed "restorative justice" as an emerging concept that stresses the intentional linking of the victim, the offender and the community in a relationship that explores ways to repair damage and address concerns about future behavior. In general, participants agreed that restorative justice provides a model for focusing attention on the harm caused by the crime, rather than on the offender and/or the substance(s) used by the offender. Participants identified this approach as one that could assist in diffusing the "black sheep" label that often serves as a barrier to change among juvenile offenders.

Participants identified many benefits (pros) of applying this model to substance abuse treatment for adolescents. Specifically, restorative justice approaches could: (1) help the offender understand and acknowledge the damage suffered by the victim and the community; (2) avoid the tendency to minimize the seriousness of the offense; (3) allow the victim to experience some level of healing; (4) allow the offender to remain a part of his/her community; (5) allow the offender, the victim and the community to understand how crime can be a function of substance-abusing behavior; and (6) promote a holistic view of individuals.

Participants also identified several problems (cons) of applying such an approach to substance abuse treatment for adolescents. Specifically, this approach could: (1) cause further damage if the situation is not handled appropriately; (2) be rejected and/or manipulated by the youthful offender; (3) lack the appropriate level of integration and/or collaboration among all involved parties; (4) lack financial support and/or funding; (5) lack the support and understanding of the community; and (6) lack a standardized, comprehensive assessment instrument. Participants stressed that the concept of restorative justice in and of itself is insufficient in dealing with the problem of substance abuse among juvenile offenders.

Question 4: Review the four models of adolescent treatment. Which, if any, is the most commonly used in your state? What are the pros and cons of these approaches?

Participants reviewed the four models of adolescent treatment and found that none of the four represented the single most commonly used approach in their respective states. Instead, they identified the 12-step model and a combination of cognitive-behavioral and family-based therapies as the most frequently used approaches throughout the region.

Following are the pros and cons of each of the four approaches as identified by the participants:

12-Step Model: Participants identified several benefits (pros) of using this model with adolescents. These include: (1) the acceptance of the model as a "proven approach"; (2) the structure of the model; (3) the "affordability" (no cost) of the model; (4) the sense of community that is fostered by others in the program who serve as role models, sponsors and mentors; and (5) the role of spirituality in this model.

Participants identified several problems (cons) of using this model with adolescents. These include: (1) the chances of encountering active users and/or dealers at meetings; (2)

the need for a large number of participants in the same age group to be effective with this population; (3) the availability of nicotine at meetings; (4) the lack of appropriateness for a diverse population of adolescents since the model was developed by adult white males; (5) the potential for adolescents to misunderstand the concept of spirituality used in the model; (6) the rigidity of the model that fails to include harm reduction approaches; and (7) the lack of 12-step meetings in many rural communities.

Participants failed to reach consensus about the appropriateness of using the 12-step model among adolescents. Some felt that the program could be modified for use among adolescents, while others felt that the model is too adult-specific and too abstract to be effective with adolescents.

Cognitive-Behavioral Treatment Model: Participants identified several benefits (pros) of using this model with adolescents. These include: (1) the teaching of coping skills; (2) the promotion of a holistic approach to treating adolescents; (3) the use of developmentally appropriate techniques; (4) the increased probability that the adolescent will see a connection between situations in which his/her thinking is rational and those in which his/her thinking is irrational; and (5) the recognition of bio/medial aspects of abuse/dependence.

Participants identified several problems (cons) of using this model with adolescents. These include: (1) the failure on the part of practitioners to provide alternative approaches for adolescents with limited cognitive skills; (2) the lack of commitment on the part of provider agencies to allocate the time required for this type of treatment; (3) the lack of resources required to train and assess the skills of providers; and (4) the lack of compatibility with the disease model of addiction.

Family-Based Treatment Model: Participants identified several benefits (pros) of using this model with adolescents. These include: (1) the importance of viewing the entire family as part of the solution; (2) the compatibility of this model with the concepts of restorative justice; (3) the exposure of parents to new or alternative models of parenting/family management; (4) the ability of the model to assist in identifying barriers to change; (5) the ability of the model to improve treatment outcomes; and (6) the cost-effectiveness of this model as compared to the cost of incarceration.

Participants identified several problems (cons) of using this model with adolescents. These include: (1) the difficulty of engaging the entire family in treatment; (2) the need for extensive knowledge of and access to community resources; (3) the tendency to omit or overlook adolescents who are not part of "traditional" families, for example, homeless youth, foster children and others; (4) the potential for emotional harm that can occur when members reveal their "family secrets"; (5) the potential to reduce the number of clients who can be served by the program; and (6) the lack of opportunities for peer involvement in the model.

Therapeutic Community Treatment Model: Participants identified several benefits (pros) of using this model with adolescents. These include: (1) the structured environment of the model; (2) the long-term nature of the model that promotes consistency and continuity; (3) the safe "family-type" atmosphere of the setting; and (4) the teaching of critical life skills, including those that promote accountability, individual responsibility and independence.

Participants identified several problems (cons) of using this model with adolescents. These include: (1) the history of aggressive confrontation that is often used in this model that can present barriers for some adolescents, especially those with poor social management skills, as well as females; (2) the lack of aftercare or transitional services for the adolescents once they leave the treatment program; (3) the lack of skills on the part of adolescents to appropriately manage one another; and (4) the presence of personal agendas that are not conducive to the therapeutic process.

Question 5: Review the five treatment approaches that research has shown to be effective with adolescents. How do the models used in your state incorporate these evidence-based approaches? Are these models and/or approaches holistic? How would you describe a holistic approach to adolescent addiction treatment?

Participants reviewed the five treatment approaches that research has shown to be effective with adolescents, and they felt that most adolescent substance abuse treatment clinicians incorporate portions of these five approaches into their existing treatment regimens. They acknowledged, however, that the combination of the various approaches does not always allow these efforts to be implemented with fidelity unless the programs are funded as part of a special project or initiative.

Participants examined the holistic nature of the five approaches and agreed that each one has some missing components. Participants agreed that holistic treatment begins with a thorough bio/psycho/social/spiritual assessment that in turn provides the framework for a treatment plan that is developed in collaboration with the adolescent, along with the service providers from both the juvenile justice and substance abuse treatment systems. In a holistic model, services such as academic tutoring, legal assistance, child care, health care, pre-employment training, psychiatric care, spirituality and safe housing become part of a comprehensive system. Barriers to such a level of integration and comprehensiveness as identified by the participants included the following: (1) the reluctance of state-level adolescent substance abuse treatment and juvenile justice programs to address barriers to integration and collaboration; and (2) the lack of a strategic plan at both the state and community levels that addresses the provision of holistic services for adolescents.

Based on the varied experiences of the participants with each of the five models, several concerns were raised by the participants about each of the approaches. These include the following:

Motivational Enhancement Therapy/Cognitive-Behavioral Therapy (MET/CBT5) Approach: Participants acknowledged that this approach has fairly widespread recognition throughout the region. In addition, they acknowledged that many of the states were using some adaptation of this approach in their respective programs. However, they felt that the approach can be costly and is often less effective when used with adolescents with low intellectual levels.

CBT7 Approach: Participants who had used this approach felt that the substance abuse field is still learning about the impact of psychoactive substances on brain function and that drug use can impact rational thought processes, thus hindering the effectiveness of this treatment approach.

Family Support Network Approach: Participants who had implemented this approach expressed their concerns about complications when the approach is used with incarcerated juveniles. In addition, some participants had found this approach to be counter productive when used in certain situations, such as those involving antagonistic family members.

Adolescent Community Reinforcement Approach: Participants who had implemented this approach liked the longer duration of treatment contact but found that this also raised concerns about issues related to transportation and the commitment of time required for services.

Multidimensional Family Therapy Approach: Participants who had implemented this approach reported generally positive outcomes when efforts had been coordinated with a comprehensive wraparound process. Despite its successes, however, participants expressed concerns about the cost-effectiveness of this approach.

Question 6: Review each of the 15 core components recommended for substance abuse treatment programs among adolescents. Which present the greatest challenge at the state level? At the community level? What can be done to overcome these challenges?

Participants reviewed the 15 core components recommended for substance abuse treatment programs for adolescents and found six of the 15 core components as presenting the greatest challenge at the state level. These are: (1) using treatment models based on research and evaluation that have been found to be effective with substance-abusing juvenile offenders; (2) screening to identify youth at an early stage in the system; (3) conducting a comprehensive assessment that evaluates the youth's risks, needs, strengths and motivation and matches the youth to appropriate treatment based on the assessment; (4) building support for treatment efforts at all levels of institutions, systems and communities; (5) developing interagency collaboration among all youth service providers; and (6) implementing a management information system that can be used to share information across programs and systems.

Participants recommended several actions that can be taken to address these challenges. Their recommendations included: (1) increasing flexibility among agencies that serve youth through the sharing of information across programs and systems; (2) developing a strategic planning process at the state level that: (a) promotes the use of treatment models that are based on research and evaluation, (b) recommends specific outcome measures, and (c) links funding with outcomes; and (3) increasing the involvement of youth and of representatives from the substance abuse and juvenile justice systems who reflect diverse cultural, racial and gender profiles in all phases of program planning and development.

In addition, participants identified the following core components as those that present the most significant challenges at the community level: (1) developing and using a strategic planning process; (2) developing interagency collaboration; (3) implementing a management information system that can be used across programs and systems; (4) providing overarching case management across systems and over time; (5) involving the family in all aspects of the youth's treatment; and (6) using resources effectively.

Participants recommended that these core components can be improved at the community level if state substance abuse and juvenile justice agencies: (1) model them through their own planning, funding and accountability measures; (2) advocate for needed legislative changes;

(3) involve communities in the planning process; (4) agree to provide client services in the same location; and (5) conduct a cost-benefit analysis and other quality improvement activities to maximize resources and effectiveness.

In addition, participants recommended that communities should develop a strategic plan for the provision of substance abuse treatment among juvenile offenders. Such a plan would include the involvement of key stakeholders in an in-depth, interactive process similar to the one used at the Leadership Institute. Participants recommended that state and federal agencies should provide resources to assist communities with this strategic planning process and with accessing information on funding for services identified through the process.

Question 7: How female-sensitive are substance abuse treatment programs for adolescents? What can be done to improve treatment outcomes for female substance-abusing adolescents?

Participants agreed that most substance abuse treatment research had involved males, and they felt that efforts to generalize the findings from these studies to females, particularly adolescent females, may at times result in inappropriate assumptions. Participants noted, based on their experience, that fewer females than males enter substance abuse treatment programs, and they suggested that this might be because females tend to internalize their problems, a tendency that often results in more medical problems or depression among this population. Conversely, however, males tend to externalize their problems, a tendency that is more likely to lead to behaviors that result in referrals to substance abuse treatment and juvenile justice programs. Participants recommended that both state and federal substance abuse and juvenile justice agencies should collaborate on the identification of gender-specific issues and treatment tracks for female adolescent substance abusers, and they suggested that this might be an appropriate topic for one of the National Institute on Drug Abuse's Clinical Trials. Participants recommended that adolescent substance abuse treatment and juvenile justice agencies should collaborate to find better ways to identify female substance abusers at an earlier point and to provide appropriate interventions for this population. In addition, participants noted that adolescent males also present unique gender-specific issues for treatment, and they recommended that the current models and approaches identified earlier should be reviewed for appropriateness in addressing gender-related issues among both male and female adolescents. Participants recognized that gender-specific approaches are not exclusive, but instead are viewed as realistic, natural and appropriate for meeting the needs of the target populations.

Question 8: Are some adolescent substance abusers untreatable? If so, what can states and/or communities do to plan for untreatable adolescent substance abusers?

Participants agreed that some adolescent substance abusers present a complex combination of attitudes, behavior disorders and resistance that might be incompatible with a program's clinical values and operational processes, thus leading to their labeling as "untreatable." Participants felt that this term has a negative connotation, and they recommended the use of more descriptive terms for adolescents who are not responding to treatment, including "teens with complex needs/issues" or "teens with hard-to-treat symptoms/disorders." Participants recommended several measures to reduce the likelihood that these adolescents are excluded from the treatment process, including: (1) training all program staff in ways to reduce programmatic barriers to adolescent substance abuse treatment among all involved provider

agencies; (2) training program staff on effective approaches to working with this population, placing specific emphasis on the role of ego defense mechanisms in the early phases of treatment; (3) integrating an appropriate wraparound process that expands the treatment menu to include pre-treatment interventions, holistic treatment options and relapse prevention strategies; (4) supporting research to identify effective "brief interventions" with this population; (5) supporting research to identify criteria to describe the adolescent substance-abusing population; and (6) establishing agreed-upon critical elements of a crisis plan for adolescents who might fall within this category. Participants recommended that states should identify the wraparound process required for teens with complex needs/issues and take appropriate actions, including making legislative changes, to ensure the provision of these services for this population.

Question 9: What do you recommend as measurable outcomes for substance abuse treatment among juvenile offenders?

Participants recommended that state substance abuse and juvenile justice agencies should develop, with input from community providers, an agreed-upon list of measurable outcomes for substance-abusing juvenile offenders. Participants identified the examples of outcome measures as referenced on Pages 106-108 in the 1999 CSAT publication, titled *Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide,* as useful information to assist states with this process.

In addition, participants identified several outcome measures that are appropriate for application in the following four areas of a substance-abusing juvenile offender's life:

Alcohol, Nicotine and Other Drug Use: Examples of outcome measures recommended for this area include: (1) abstinence; (2) reductions in the use of these substances, including the frequency, amount and severity; (3) enhanced refusal and coping skills; (4) active implementation of a relapse prevention plan; and (5) increases in the number of negative urinalyses or other drug tests.

Legal: Examples of outcome measures recommended for this area include: (1) reductions in the number of repeat offenses, including frequency and severity; and (2) compliance with probation requirements.

Education/Work: Examples of outcome measures recommended for this area include: (1) improvements in school attendance; (2) improvements in school functioning; (3) improvements in job-related performance; and (4) reductions in school- or work-related disciplinary actions.

Family/Community: Examples of outcome measures recommended for this area include: (1) increases in pro-social community involvement (sports, hobbies, religious activities, etc.); (2) increases in positive family relations, such as family management practices or communications; (3) establishment of a positive personal support network; (4) reductions in personal crises requiring outside interventions, such as out-of-home placements; and (5) reductions in personal health-related problems, including sexually transmitted diseases, unwanted pregnancies and others.

Policy Issues for the Prevention of Substance Abuse Among Juvenile Offenders

Participants began their dialogue on this issue by reaching consensus on several fundamental issues as identified by the following questions.

Question 10: Is there conceptual clarity of the term "prevention" among juvenile justice and substance abuse prevention professionals?

Participants recognized that professionals in the fields of juvenile justice and substance abuse have differing levels of understanding of the term "prevention." Specifically, they felt that substance abuse prevention professionals have a clear understanding of the broad nature of the term to include the Public Health Model of Prevention, which defines primary, secondary and tertiary levels of programming, as well as the Institute of Medicine's definition, which includes "universal" prevention (for a broad general audience); "selected" prevention (for high-risk individuals); and "indicated" prevention (for those with identified problem behaviors).

Participants felt that juvenile justice professionals historically have viewed the term "prevention" as any type of intervention activity that might possibly help adolescents avoid future offenses. Participants acknowledged, however, that juvenile justice professionals have a clear understanding of "indicated" prevention and that the field in general has a growing knowledge of both "universal" and "selected" prevention.

Question 11: What are the barriers to using evidence-based prevention with juvenile offenders?

Participants identified several barriers to using evidence-based prevention with juvenile offenders. Among these are the following: (1) the lack of conceptual clarity between substance abuse and juvenile justice professionals regarding the definition and role of "prevention" among juvenile offenders; (2) the lack of availability of evidence-based approaches that are designed specifically to meet the unique needs of the juvenile justice population; (3) the inconsistency within the substance abuse system as to which programs meet the criteria for "evidence-based"; (4) the inability of existing programs to "fit" the juvenile justice population; (5) the lack of family involvement in these approaches; (6) the lack of sufficient human and fiscal resources needed to implement evidence-based approaches; and (7) the lack of sufficient time required to implement these efforts.

In addition, participants felt that substance abuse professionals lack an understanding of the juvenile justice system's need to focus on selected and/or indicated prevention programs, and they felt that additional research is needed to determine the efficacy of these approaches. Participants recommended that substance abuse and juvenile justice professionals should collaborate on the development of strategies to implement all levels of prevention (universal, selected and indicated) among all segments of the juvenile justice population.

Question 12: Review the section on risk and protective factors. Should the focus be on programs to reduce risk factors, strengthen protective factors, or both?

Participants agreed that prevention efforts that focus on any single risk or protective factor are insufficient in working with this population and recommended instead a holistic approach to prevention that addresses an appropriate balance of both risk and protective factors. In

addition, participants recommended that prevention programs should be based on an ongoing assessment of risks and protective factors that fall within the various domains of life (individual, family, peer, community, school and society). Participants noted that prevention programs that focus only on risk factors have the potential to identify legitimate, powerful systemic issues that influence the problem behavior. Participants recognized the danger inherent in such an approach, however, as it would fail to develop strengths or assets among the offender population.

Question 13: Does your state or community have a strategic plan to prevent substance abuse among adolescents? Does it have a strategic plan to prevent youth involvement in crime? Are these plans linked?

Participants drew upon their own knowledge and experiences to identify whether their respective states have existing strategic plans to prevent substance abuse and/or juvenile crime. Participants noted that not all of the Southeastern states were represented at the Leadership Institute and that gaps existed in their knowledge of these planning activities at the state level. However, participants agreed that if such strategic plans do already exist in their states, this fact in and of itself highlights a gap in communication, as the plans have not been sufficiently disseminated to all professionals who work in these arenas.

Participants recognized that five states in the region (Florida, Kentucky, Mississippi, North Carolina and South Carolina) have received funding from the U.S. Center for Substance Abuse Prevention through its State Incentive Grant program, and it is likely that these five states have some type of initiative under way to develop comprehensive substance abuse prevention strategies. Participants acknowledged that some of these plans might include efforts to link with the juvenile justice system.

Participants strongly recommended that state substance abuse and juvenile justice agencies should work in collaboration with other statewide and community youth-serving agencies and organizations to develop a strategic planning process to address the prevention of substance abuse and delinquency among adolescents.

Question 14: Review the components of a prevention resource system. Does such a system exist in your state or community? What are the barriers to developing prevention resource systems?

Participants agreed that most states in the region have some variation of a prevention resource system at both the state and community levels. However, participants questioned how well the agencies and organizations that comprise these systems are coordinating their efforts. In addition, participants identified several barriers among states and communities to developing such systems. These include: (1) the existence of "turf" issues that often hinder effective collaboration; (2) the failure to devote sufficient time to such efforts; (3) the belief that prevention is sometimes superficial and "out of touch" with real needs; (4) the lack of training among service providers regarding effective prevention approaches; (5) the exclusion of non-science-based practices on the part of some prevention efforts; (6) the lack of a cooperative infrastructure within some prevention programs; (7) the lack of adequate and sustained funding; (8) the resistance to change on the part of substance abuse and juvenile justice professionals; and (9) the lack of involvement of substance abuse treatment professionals in the implementation of efforts to reduce youth access to alcohol and nicotine.

Participants recommended that state and community substance abuse and juvenile justice agencies should strengthen the integration of their planning and programming activities in order to avoid the fragmentation of services. In addition, they recommended that both systems should be more receptive to efforts to involve the field of law enforcement in their planning and programming efforts to target this population. Finally, they recommended that state substance abuse and juvenile justice agencies should place a high priority on the development of a competent prevention workforce, to include offering incentives for their prevention staff members to become certified.

Summary Recommendations

Participants of the Leadership Institute concluded their dialogue on the topic of "Substance Abuse Among Juvenile Offenders: Policy Issues for Prevention and Treatment" by making the following three summary recommendations for action:

- The directors of the member agencies of the Southeastern Conference on Alcohol and Other Drug Programs Inc. should involve the representatives of the Leadership Institute from their respective states in a focused effort to review these proceedings and explore the next steps that are required to implement the recommendations identified herein.

- The chair of the Southeastern Conference on Alcohol and Other Drug Programs Inc. should request periodic updates from the directors of the member agencies to track the progress made in each state on the consideration and implementation of these recommendations.

- The Southeast Addiction Technology Transfer Center should provide periodic updates to the participants of the Leadership Institute, as well as to the Southeastern Conference on Alcohol and Other Drug Programs Inc., regarding the Center's evaluation of the impact of the Leadership Institute on systems changes within the participating states.

Appendix I
Participants of the 2002 Leadership Institute

Richard D. Barbee
Level 3 Alcohol and Drug Program
Designer/Director/Implementer
Mountain View YDC
3135 Washington Ridge, #1306
Knoxville, Tennessee 37917
Tele: (865) 397-0174, ext. 212
E-mail: rbarbee@utk.edu; or
rich10ac@msn.com

Stephen Brunt
Director
Sunflower Landing Adolescent
Treatment Center
P.O. Box 23
Dublin, Mississippi 78963
Tele: (662) 624-4905
Fax: (662) 624-5013

Bob Carton
EAP Counselor
Tallahassee Memorial Healthcare EAP
1616 Physicians Drive
Tallahassee, Florida 32308
Tele: (877) 501-0956
Fax: (850) 431-5147
E-mail: cartonbob@yahoo.com

Kari Collins
Kentucky River Community Care
Community Way, Highway 15
Jackson, Kentucky 41339
Tele: (606) 666-9006
Fax: (same as telephone number)
E-mail: kecinky@hotmail.com

Lisa Crain
Director of Substance Abuse Services
Gulf Coast Mental Health Center
1600 Broad Avenue
Gulfport, Mississippi 39501
Tele: (228) 863-1132
Fax: (228) 865-1700
E-mail: lcrain@gcmhc.com; or
lkc_gcmhc@hotmail.com

Carolyn R. Dunlap*
South Carolina Department of Alcohol and
Other Drug Abuse Services
101 Business Park Boulevard
Columbia, South Carolina 29203-9498
Tele: (803) 896-5555
Fax: (803) 896-5557
E-mail: cdunlap@daodas.state.sc.us

Mike Dennis
William J. McCord Adolescent Treatment
Facility
P.O. Box 1166
Orangeburg, South Carolina 29116
Tele: (803) 534-2328, ext. 113
Fax: (803) 531-8419
E-mail: mdennis@tccada.state.sc.us

Mitchell L. Dent
Vicksburg Family Development
103 Montaign Drive
Vicksburg, Mississippi 39180
Tele: (601) 638-1336
E-mail: md4_dent@msn.com

Lewis E. Gallant
National Association of State Alcohol and
Drug Abuse Directors
808 17th Street, N.W., Suite 410
Washington, D.C. 20006
Tele: (202) 293-0090
Fax: (202) 293-1250
E-mail: lgallant@nasadad.org

Kay Gresham
Southeast Addiction Technology Transfer
Center
720 Westview Drive, S.W.
Atlanta, Georgia 30310-1495
Tele: (404) 756-5745
Fax: (404) 752-1152
kgresham@msm.edu

*Faculty

Darcy Hayes
Community Counseling Services, Region VII
P.O. Box 1188
Starkville, Mississippi 39760
Tele: (662) 494-8586
E-mail: dmp2@msstate.edu

Barry Kellond
Division of Substance Abuse
100 Fair Oaks Lane, 4 E-D
Frankfort, Kentucky 40621
Tele: (502) 564-3487
Fax: (502) 564-7152
E-mail: Barry.Kellond@mail.state.ky.us

Lee Lewis
Branch Head
Adolescent Substance Abuse Services
325 N. Salisbury Street
Raleigh, North Carolina 27699-3007
Mail Service Center 3007
E-mail: lee.lewis@ncmail.net

James A. Neal*
Southeastern Conference on Alcohol and
Other Drug Programs, Inc.
700 Greenlawn Drive, Apt. 807
Columbia, South Carolina 29209
Tele: (803) 776-8063
E-mail: jimbjneal@aol.com

Bonnie Peterson
Program Director
Youth Development Program
Memphis Recovery Center
219 N. Montgomery
Memphis, Tennessee 38104
Tele: (901) 272-7751
E-mail:
bonniepeterson@memphisrecovery.com

Nancy K. Pfaadt
Early Intervention Consultant
D.S.A. Special Programs
Eastern Kentucky University
219 Old Towne Road
Louisville, Kentucky 40214
Tele: (502) 363-4262
Fax: (same as telephone number)
E-mail: npfaadt@aol.com

Cassie Russell
MYDC
495 Forest Hills Drive
Morehead, Kentucky 40351
Tele: (606) 784-6421
Fax: (606) 683-4000
E-mail: crussell@kih.net

Jerri Speyerer*
Prevention Services Director
Mississippi Department of Mental Health
1101 Robert E. Lee Building
239 N. Lamar Street
Jackson, Mississippi 39201
Tele: (601) 359-1288
Fax: (601) 576-4040
E-mail: jspeyerer@msdmh.org

Alexis Whalen
Great Day, Inc.
246 Sycamore Street, Suite 240
Decatur, Georgia 30030
Tele: (404) 378-8553
Fax: (888) 860-5403
E-mail: greatdayinc@yahoo.com

Geoff Wilson
Pathways, Inc./Hillcrest Hall
P.O. Box 385
Mt. Sterling, Kentucky 40353
Tele: (859) 498-6574
Fax: (859) 498-7325
E-mail: gwilson@pathways-ky.org

Appendix II
Shared Risk Factors and Their Relationship to Adolescent Problems

Risk Factors Occurring in Various Domains	Substance Abuse	Delinquency	Teen Pregnancy	School Dropout	Violence
Community					
• Availability of drugs	*				
• Availability of firearms		*			*
• Community laws and norms that are favorable toward drug use, firearms and crime	*	*			*
• Media portrayals of violence					*
• Transitions and mobility	*	*		*	
• Low neighborhood attachment and community disorganization	*	*			*
• Extreme economic deprivation	*	*	*	*	*
Family					
• Family history of the problem	*	*	*	*	
• Family-management problems	*	*	*	*	*
• Family conflict	*	*	*	*	*
• Favorable parental attitudes and involvement in the behavior	*	*			*
School					
• Early and persistent antisocial behavior	*	*	*	*	*
• Academic failure in elementary school	*	*	*	*	*
• Lack of commitment to school	*	*	*	*	
Individual/Peer					
• Alienation and rebelliousness	*	*		*	
• Friends who engage in the problem behavior	*	*	*	*	*
• Favorable attitudes toward the problem behavior	*	*	*	*	
• Early initiation of the problem behavior	*	*	*	*	*
• Constitutional factors	*	*			*

Appendix III
Substance Abuse Risk and Protective Factor Framework

Risk- and protective-factor prevention is based on the premise that to prevent a problem from happening, we need first to identify the factors that increase risk and use evidence-based ways to reduce those risks or increase the potency of protective factors that buffer individuals from those risks. The following chart shows the risk and protective factors for substance abuse in six areas of life or "domains."

Domain	Protective Factors	Risk Factors
Individual	• Positive personal characteristics including social skills and social responsiveness; cooperativeness; emotional stability; positive sense of self; flexibility; problem-solving skills; and low levels of defensiveness • Bonding to societal institutions and values, including attachment to parents and extended family; commitment to school; regular involvement with religious institutions; and belief in society's values • Social and emotional competence, including good communication skills; responsiveness; empathy; caring; sense of humor; inclination toward pro-social sense of purpose and of the future (e.g., goal-directedness); and self-discipline	• Inadequate life skills • Lack of self-control and assertiveness • Low self-efficacy • Emotional and psychological problems • Favorable attitudes toward substance use • Rejection of commonly held values and religion • School failure • Lack of school bonding • Early antisocial behavior, such as lying, stealing and aggression, particularly in boys, often combined with shyness or hyperactivity
Family	• Positive bonding among family members • Parenting that includes high levels of warmth and avoidance of severe criticism; sense of basic trust; high parental expectations; and clear and consistent expectations, including children's participation in family decisions and responsibilities • An emotionally supportive parental/family milieu, including parental attention to children's interests; orderly and structured parent-child relationships; and parent involvement in homework and school-related activities	• Family conflict and domestic violence • Family disorganization • Lack of family cohesion • Social isolation of family • Heightened family stress • Family attitudes favorable toward drug use • Ambiguous, lax or inconsistent rules and sanctions regarding substance use • Poor child supervision and discipline • Unrealistic expectations for development

Peer	• Association with peers who are involved in school, recreation, service, religion or other organized activities	• Association with delinquent peers who use or value dangerous substances • Association with peers who reject mainstream activities or pursuits • Susceptibility to negative peer pressure • Strong external locus of control
School	• Caring and support; sense of "community" in classroom and school • High expectations from school personnel • Clear standards and rules for appropriate behavior • Youth participation, involvement and responsibility in school tasks and decisions	• Ambiguous, lax or inconsistent rules and sanctions regarding drug use and student conduct • Favorable staff and student attitudes toward substance use • Harsh or arbitrary student-management practices • Availability of dangerous substances on school premises • Lack of school bonding
Community	• Caring and support • High expectations of youth • Opportunities for youth participation in community activities	• Community disorganization • Lack of community bonding • Lack of cultural pride • Lack of competence in majority culture • Community attitudes favorable toward drug use • Ready availability of dangerous substances • Inadequate youth services and opportunities for pro-social involvement
Society	• Media literacy (resistance to pro-use messages) • Decreased accessibility • Increased pricing through taxation • Raised purchasing age and enforcement • Stricter laws on driving while under the influence	• Impoverishment • Unemployment and underemployment • Discrimination • Pro-drug-use messages in the media

Filename: Final Report.doc
Directory: D:\Documents and Settings\bomayo\Local Settings\Temporary Internet Files\OLK48A
Template: D:\Documents and Settings\bomayo\Application Data\Microsoft\Templates\Normal.dot
Title: Substance Abuse Among Juvenile Offenders: Policy Issues for Prevention and Treatment
Subject:
Author: Valued Customer
Keywords:
Comments:
Creation Date: 9/11/2002 9:05 AM
Change Number: 2
Last Saved On: 9/11/2002 9:05 AM
Last Saved By: Barry R Kellond
Total Editing Time: 0 Minutes
Last Printed On: 1/24/2003 10:31 AM
As of Last Complete Printing
Number of Pages: 44
Number of Words: 19,757 (approx.)
Number of Characters: 112,618 (approx.)